Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address:

MARIA M GRANADOS
15143 CHIPMAN LANE
HOUSTON TX 77060

Respondent Name:
TASB RISK MGMT FUND

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number:
M4-12-0683-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The Requestor did not submit a position summary with the request for medical fee dispute resolution.

Amount in Dispute: $349.95

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The injured worker did not submit a DWC-60, copies of receipts of proof of payment or convincing evidence of the employee's attempt to obtain reimbursement or refund from the carrier or health care provider. TASBRMF does not feel the injured worker submitted the correct documentation timely."

Response Submitted by: TASB, PO Box 2010, Austin, TX 78768-2010

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 17, 2010 through October 4, 2010	Out-of-Pocket expenses for Office Visits and Prescription Medications	$341.86	$0.00
August 17, 2011	Out-of-Pocket expenses for Prescription Medication	$8.09	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.270 sets out the procedures for injured workers to submit workers' compensation medical bills for reimbursement.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   EOBs were not submitted by either party.

Issues

1. Did the requestor submit out-of-pocket expenses in dispute timely and in accordance with 28 Texas Administrative Code §133.307?
2. Did the requestor submit documentation to support the request for reimbursement from the insurance carrier for out-of-pocket expenses was made in accordance with Texas Labor Code §133.307?
3. Is the requestor entitled to reimbursement?

Findings

1. Medical Fee Dispute Resolution received the request for medical fee dispute resolution on November 2, 2011. Pursuant to 28 Texas Administrative Code §133.307(c)(1)(A) dates of service February 17, 2010 through October 4, 2010 were not submitted within the one year filing deadline and are not eligible for review. Date of service, August 17, 2011 was submitted timely and will be reviewed in accordance with Division Rules and the Statute.
2. In accordance with 28 Texas Administrative Code §133.307(c)(3)(D); the injured worker did not submit documentation to support that a request for reimbursement was made to the insurance carrier prior to requesting medical dispute resolution for date of service August 17, 2011. Therefore reimbursement is not recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is not due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 21, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.